State Child Fatality Review Report
SFY 02-03
G.S. 143B-150.20

Family Support and Child Welfare Services Section
Division of Social Services
NC Department of Health and Human Services

2004

Report to the General Assembly
From the State Fatality Review Team

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Executive Summary

The Department of Health and Human Services, Division of Social Services, has the responsibility to convene a State Child Fatality Review Team to "conduct in-depth reviews of the child fatality which occurred involving children and families involved with local Departments of Social Services child protective services in the 12 months preceding the fatality." The purpose of these reviews is to "implement a team approach to identifying factors which may have contributed to conditions leading into the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies." These reviews are mandated by statute (G.S. 143B-150.20) with specified team membership that includes representatives from the Division of Social Services, the county DSS, representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.

The reviews consist of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children. A formal report is issued at the conclusion of each review that includes the findings and recommendations from the State Child Fatality Review Team. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it. Following the issuance of each report, Division of Social Services staff present the recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each state level recommendation.

During SFY 02-03, 18 final fatality review reports were issued following completion of the reviews. During the year, the Division of Social Services identified 34 child fatalities that met the criteria for a State Child Fatality Review Team review out of 135 deaths reported. Out of the 34 deaths, neglect was suspected to have contributed to the fatality in 24 cases and abuse was suspected in 10.

Throughout the reviews conducted during the year, review teams identified six major themes most often. First, the review teams identified the need for Division of Social Services agencies to improve and expand upon their reporting and intake process, specifically around reports of domestic violence and substance misuse. Second, many of the fatality reviews identified the need for a consistent protocol for information sharing across counties. Related to the issues of sharing information is the need for clarification of confidentiality laws and policies. The third major theme involved the need for Child Protection Services to have immediate access to the Administrative Office of Courts Data System. The fourth major theme identified was the impact of Domestic Violence in the Community. The need for Spanish Speaking Resources constituted the fifth major theme. Finally, collaboration between DSS and DMH/DD/SAS continues to be a finding from the child fatality reviews. Additional themes and issues were identified and are listed in Appendix A to this report. Appendix B lists accomplishments by local communities as a result of recommendations from reviews.

State Child Fatality Review Team
Annual Report

Pursuant to G.S. 143B-150.20, following is the State Child Fatality Review Team annual report to the N.C. General Assembly for SFY 02-03. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 02-03. These teams conduct multidisciplinary reviews when there is suspicion that neglect or abuse caused a child's death and the county DSS children's services program was involved with the child or family any time in the previous year.

I. History

In 1997, the General Assembly enacted G.S. 143B-150.20 and established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local departments of social services child protective services in the 12 months preceding the fatality.

The collaborative, multi-disciplinary approach to these reviews, along with information available to the public through the review reports, make these reviews learning tools for the entire community. These reviews can teach us how we can improve our efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams has been that there is ownership by the local communities with Review Team recommendations and commitment to implementation of the resulting action plans. The State Child Fatality Reviewers have implemented six-month follow-up contacts with the local Community Child Protection Teams (CCPT's) after a review is completed. These follow-up contacts with the CCPT's focus on the progress at the local level in implementing any systemic changes as a result of the recommendations from the Review Team.

II. Review Process

Currently, child fatality reviews are conducted as follows:

1. By State law, anyone who has cause to suspect that a child has died as the result of maltreatment must report the case to the director of the county Department of Social Services (DSS).
2. The DSS reports to the Department of Health and Human Services, Division of Social Services (the Division) information that they receive regarding any child who is suspected to have died as a result of maltreatment.
3. The Division determines whether the necessary criteria are met to invoke a review by a State Child Fatality Review Team based on information from the county DSS and any local law enforcement or health care professional who was involved in investigating the child's death or the death scene.

4. A State Fatality Review Team is convened, including representatives of the Division of Social Services, the county DSS, and representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.
5. Division staff on the team begins all reviews with an introduction about the review process to all participants.
6. The review consists of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children.
7. The team writes a report that includes the findings of the review and recommendations for system improvement.
8. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it.
9. As each State Child Fatality Review Report is completed and released, Division staff present recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each recommendation. For recommendations that need to be addressed by the Division, a work group established in the Family Support and Child Welfare Services Section (FSCWS) examines the issues identified and presents the recommendations to the FSCWS Management Team for any necessary action.

III. Facts regarding State Child Fatality Review Process

The State Child Fatality Review process is an ongoing one, and there is overlap from one fiscal year to the next. Therefore, reviews conducted and reports issued include fatalities that were reported to the Division and decisions to conduct reviews from the previous fiscal year as well as those from the current fiscal year. Some of the cases identified for review in the current fiscal year will be reviewed in the next fiscal year. During SFY 02-03, 18 final fatality review reports were issued following completion of reviews. One review involved the deaths of three siblings.

The State Division of Social Services identified 34 child fatalities (out of 135 deaths reported) in 27 counties that met the criteria for a State Child Fatality Review Team review during SFY 02-03. One of those 34 child fatalities involved three siblings. To meet the criteria for a State Child Fatality Review, there had to be a suspicion that abuse or neglect was a factor in the fatality. In addition, the child or family must have been involved with a county department of social services child protective services in the 12 months preceding the fatality. Of these 34 child deaths, neglect was suspected in 24 cases and abuse was suspected in 10 cases.

IV. Lessons Learned

The State Child Fatality Review Teams often identify similar issues in the cases that they review. At other times, there may be a major issue identified that had not been noted previously but that has statewide impact. Other findings are more case specific or community specific.

The six most commonly identified major findings and lessons learned from the 18 child fatality reviews completed during SFY 02-03 are summarized here so that the State Division of Social Services, county departments of social services, and other state and county agencies can make systemic improvements focused on the safety of children. Achievements at the state level related to these findings are noted where relevant at the time the individual fatality reports were issued. Appendix A reflects recommendations that were identified less often or that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at the local level that have resulted from recommendations from State Child Fatality Reviews.

A. Information Sharing Across Counties

In the past five years and this year, the State Child Fatality Review Teams identified a critical need for more information to be shared across agencies that are involved with children and families. Most of the reviews noted that one individual or agency had important information that another individual or agency needed, and that information was not shared as well as interagency collaboration is key to serving families and protecting children. In addition, information sharing across county lines and from one state to another has special challenges for county DSS agencies in their efforts to protect children and adequately serve families.

In several of the child fatalities reviewed, the review teams found that human services agencies involved with the same families experienced difficulty in accessing and sharing information with one another, which affected each agency's ability to intervene with the families appropriately. There was resulting lack of coordination regarding decision-making or case planning with the families by the involved agencies. Although there were multidisciplinary teams established in some of the cases, not all agencies involved fully participated.

Frequently, there was a lack of clear understanding between agencies regarding their individual roles, agency guidelines, degree of expected involvement, and language. At times, information was eventually shared across agencies involved with the families but not in a timely manner.

Recommendations from the review teams included the need for community agencies involved with serving children and families to clarify their individual roles with one another and to define for each other the constraints that their agency guidelines and mandates place on them. There is a need to avoid the use of discipline-related jargon and to determine common language so that each agency understands what is meant when dealing with the others. Once these recommendations are implemented at the local level, efforts should be made to establish specific protocols among community agencies to facilitate the timely exchange of information about children and families that they are commonly serving. All agencies should be made aware of the requirements of G.S. 7B-302(e) that allows for access to information and records by the DSS director in cases open for child protective services.

Additional recommendations addressed the need for more multi-disciplinary teams in serving families and children. These teams are critical in assessing with families their needs, in developing coordinated service plans with those families, and in case decision-making.

There are a number of initiatives underway that promote the use of multidisciplinary teams for serving families and children. Mental Health's System of Care, implemented statewide on February 1, 2001, calls for the use of such teams that include the family and all agencies serving that family coming together to identify the needs and to establish coordinated plans for intervention and service delivery. Community collaboratives also bring various agencies together to increase communication, coordinate resources and plan for local community efforts in the System of Care.

Similarly, the Family to Family initiative sponsored by the Annie E. Casey Foundation in five DSS agencies in the state prior to the completion of the child fatality reviews of fiscal year 2002-2003, promotes cross-agency collaboration and the use of Family Team Decision-Making. These teams are designed to bring the family together with their own support resources along with community resources in making placement decisions and in ensuring a network of support for children at risk of entering foster care.

General Statues require that all 100 North Carolina counties have a Community Child Protection Team (CCPT). Part of the responsibility of the CCPT is to provide an avenue to staff open CPS cases. Since the membership of the CCPT is multidisciplinary, more opportunities should be made in using the CCPT to staff particularly complicated cases that involve multiple agencies. This team staffing would promote better sharing of information among the involved agencies and better coordination of planning.

In addition to the need for sharing information across multiple agencies, the review teams identified the need for better sharing of information across county lines within North Carolina. Because children's services in North Carolina is county administered/state supervised, county lines sometimes are a barrier in serving families who move from one county to another or who have different members of the family living in different counties. Crucial information is not always readily available from one county to another, resulting in incomplete assessments of risk and safety. Case planning with families is interrupted when information is not shared timely from one county to another or when there is not a coordinated, collaborative effort between counties. When families move from one county to another when the case is open for CPS or other critical services, the transfer of services is often hampered. There were also instances identified when a family that had a CPS case open in one county moved to another county that was never notified of the family's presence.

Review teams made recommendations for a statewide protocol for timely sharing of information and case transfers across counties when families moved across county lines. The recommendations called for standardized time frames and consistent formats for thorough case summaries. In addition, there was a call for a protocol for consistent response to referrals of services to families when different members of the family live in different counties.

The Division of Social Services workgroup of state and county DSS staff completed development of a statewide policy that will address cross-county issues in child protective services, ongoing CPS in-home services, and child placement services. The new policy was effective December 15, 2003. The policy provides guidance to county departments of social services when one or more county DSS is involved with a family or child and there is confusion as to which agency has overall case management responsibility. The new policy also contains the revised N. C. G. S. 153A-257, which defines residency for social services purposes.

The exchange of information from state to state was another area identified by the review teams as a barrier to protecting children and serving families. Currently, there is no national database on child abuse and neglect that would identify children and families who have been involved with child protective services. Even when North Carolina DSS agencies have been able to determine that another state has been involved with a child and family, they have been unable to obtain full access on a timely basis to the information from the other state. The lack of timely and complete information often hampers a thorough and accurate assessment of the safety and risk to children.

Review teams recommended that North Carolina advocate with the United States Department of Health and Human Services, Administration for Children and Families (ACF), to provide protocol to all states around interstate sharing of information in child protective services cases.

The Division of Social Services has raised this issue with the ACF regional consultant for North Carolina. In addition, the Division will be contacting national associations for assistance in advocating with ACF on this issue.

B. CPS Reporting, Intake Process and Multiple Response System

All citizens are responsible for reporting child abuse. North Carolina G.S. 7B-301 states:

> Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, … or has died as a result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found.

As in previous years, the State Child Fatality Review Teams often found that reports of suspected abuse or neglect were not made to the local DSS with tragic consequences. Many reviews revealed law enforcement patrol, first responders responded several times to a home of domestic violence and substance abuse prior to the unfortunate death of a child who lived in the home. Recommendations from the fatality review teams included the need for more training in the local communities about the requirements for reporting suspected child abuse and neglect, as well as increased public awareness campaigns on how to report such suspicions. Mental health agencies, domestic violence shelters, all hospital and emergency room staff, pediatricians, emergency management staff, and law enforcement agencies need to be particularly targeted for training on recognizing signs of abuse and neglect and on the requirement for reporting suspicions to DSS. One recommendation was that there should be statewide training on the aspects of reporting child abuse and neglect for professionals outside of the DSS system and for DSS staff in other program areas, such as income maintenance staff. Another recommendation was that the Department of Health and Human Services should require all state and local agencies under the auspices of the Department incorporate in their orientation and staff training programs the aspects of reporting.

Additional clarification is needed with all first responders to child fatalities (EMS, local law enforcement, hospital emergency room staff, medical examiners) about the need to make a report to DSS when a child dies and there are surviving children in the home.

It should be noted that Children's Services Program Management Standards issued by the Division of Social Services requires that all county Departments of social services provide regular community awareness and public education programs on recognizing and reporting abuse, neglect, and dependency. Although all of the counties provide regular ongoing community awareness and public education programs, these efforts continue to be needed.

In addition to local efforts, Prevent Child Abuse North Carolina has long played a vital role in raising public awareness statewide about recognizing abuse and neglect and how to report suspicions to the local DSS. This organization has thirty (30) affiliates statewide and has the goal of identifying a member or an affiliate in each community in the state. Through their Helpline (1-800-CHILDREN), they provide information and guidance to citizens on how to report suspected abuse or neglect to DSS. They also provide a Prevention Resource Center that has public education and awareness material and training curricula that is available to local CCPT's and CFPT's. Their web site is also easily accessible at www.preventchildabusenc.org. The organization is in the process of providing training across the state for local community educators, after-school personnel, and child care employees and anticipates around 1,000 individuals being trained. This training is designed for the trainees to have the capacity to return to their local communities to train others in the community on recognizing abuse and neglect and how to report.

In addition to finding that suspicions of abuse or neglect were not always reported to DSS by the community, the review teams identified related issues that involved the DSS intake process. There were several instances where someone from the community believed that they had enough information to report to DSS. Persons making a CPS report to DSS are often emotional when reporting the information that they have. Information is best received and analyzed by the intake worker if the information is as factual as possible. One recommendation was that intake workers need to look for ways to assist callers in giving specific, factual information and in defining clearly what they mean. Clear and complete information from the reporter must be documented on the intake form including all allegations of abuse and neglect that need to be addressed by the investigative worker.

Approved by the Children's Services Committee of the North Carolina Association of County Directors of Social Services, the Division of Social Services implemented the Strengths-based, Structured Intake process and tools and became effective June 1, 2003 for all 100 counties. This Process provides social work staff with a structured intake instrument that guides discussions with reporters and utilizes decision trees to assist with more consistent intake decisions from worker to worker and county to county. The Strengths-based, Structured Intake process is one of the seven MRS strategies.
The Multiple Response System (MRS) will be able to address the many recommendations from the child fatality reviews that called for better information sharing and collaboration across agencies in serving children and families.
Also this approach provides the Division of Social Services to build on the efforts of using family-centered principles of partnership woven throughout MRS seven strategies to achieve our mission of ensuring safe, nurturing and permanent families for children. The Division of Social Services piloted the Multiple Response System in ten counties across the state in August 1, 2002. The North Carolina General Assembly authorized the expansion of the MRS demonstration project to county departments of social services. As of January 14, 2004, 41 county departments of social services will be included in the expansion which then will be a total of 51

counties practicing this approach. In one component of this MRS pilot, agencies are using Child and Family Teams in CPS in-home services cases. Like the Family Team Decision-Making meetings in Family to Family, these Child and Family Teams bring the family together with their natural supports and community resources for planning and decision-making. The other five strategies of MRS are:

1. *A choice of two approaches to reports of child abuse, neglect or dependency*
2. *Coordination between law enforcement agencies and child protective for the investigative assessment approach*
3. *A redesign of in-home services*
4. *Implementation of Shared Parenting meetings in placement cases*
5. *Collaboration between Work First and child welfare programs*

C. CPS accessibility to the Administrative Office of the Courts Data System

County departments of social services/child protective services not having immediate access of the state wide criminal information system was identified in all child fatality reviews to have severe consequences that ended in child fatalities. The child fatality reviews specifically cited that immediate safety for children and CPS worker safety was compromised because of not having immediate access to the Administrative Office of the Courts Data System (AOC) to conduct criminal background checks, especially investigations and child placements. Having accessibility to AOC will enable CPS staff to have better information to make better assessments to provide services to families.

The Division of Social Services as of December 2003 is currently piloting AOC access in collaboration with AOC to 10 counties. By the end of the fiscal year of 03-04 the Division of Social Services hopes to extend the access to all 100 county Departments of social services. The ability to access records via AOC 24 hours/7 days a week will allow CPS to conduct criminal background checks within their counties and statewide.

D. Domestic Violence in the Community

12 out of 18 child fatality reports involved domestic violence. Violence committed by family members upon other family members has plagued North Carolina for many years. There has been a reluctance to acknowledge the extent of this violence as well as the tremendous societal costs it to bear, has frustrated efforts to reduce it. In the face of this reluctance, two strong but separate movements, the movement to prevent child abuse and the battered women's movement have emerged.

In 2002, Chief Justice I. Beverly Lake and Secretary of Health and Human Services Carmen Hooker Odom enthusiastically agreed to chair a task force and appointed 40 members. The task force mission was to design a strategy for North Carolina to adopt policies and practice recommendations and an implementation plan that maximizes the safety of all family members, empowers victims, and holds perpetrators

of domestic violence and child maltreatment accountable. One of the workgroups of the Division of Social Services, county Department of Social Services, and Domestic Violence experts convened to take the recommendations from the task force and integrate those recommendations into policy and practice as it relates to child protective services. The workgroup also is examining long standing issues confronting CPS workers and Domestic Violence professionals. These issues are so important to both child and the non-offending partner safety, and to batterers' accountability, and therefore are drafting specific domestic violence procedures and policies as social workers conduct assessments in these families.

E. Spanish Speaking Resources

It is imperative that we are able to communicate clearly with the population we serve. North Carolina has experienced a growth of the Spanish speaking population by 300%, according to the recent census. This population is seeking our services in high numbers. 95% of North Carolina DSS county agencies are experiencing serving high numbers of Spanish speaking population and do not have the interpreter or Bi-lingual capacity to effectively serve this population. 3 out of the 18 child fatality reports were children of Spanish decent. More than 4% of North Carolina's citizens speak Spanish as their primary language. The majority of the Latino/Hispanics that comprise 5.6% of the Work First caseload and 5% of the Medicaid caseload do not read nor understand English.

Given the large and growing Spanish-speaking population in North Carolina a Latino Health Task Force was formed and published a report in 2003. Responding to the efforts of the Latino Task Force and complying with Title VI of the Civil Rights Act, DHHS is providing bi-lingual materials available for all programs, bi-lingual interpreters are available, ensuring diversity programs are implemented within DHHS, and diversity fundamentals are implemented into all policy and practice. These efforts will address recommendations from the Child Fatality Reviews for the need of bi-lingual services.

F. Collaboration between DSS and DMH/DD/SAS

In many of the fatalities reviewed, the review teams identified the need for better collaboration between DSS and DMH/DD/SAS agencies at the local level. In a number of the reviews, there were concerns about how the new Mental Health State Plan would impact the availability for services to children and parents that are involved with child protective services across the state. Particularly, rural areas currently experience poor access to mental health services for DSS clients. Also, the oversight of contracted providers needs to be carefully monitored as it relates to ensuring the safety of children, appropriate placements through Mental Health or Developmental Disabilities, and ongoing services.

When families move from one area of the state to another, there should be a mechanism in place to ensure that Mental Health services are provided and coordinated in the county of residence regardless of where the services originated. Although procedures exist for facilitating a memorandum of understanding regarding transfer of responsibility for care coordination and services delivery, protocols should be reviewed to assure effective continuity of care. These protocols are particularly needed in cases that also have involvement with DSS.

Better communication and collaboration between local DSS and Mental Health agencies was indicated in several cases where the DSS had made a referral to Mental Health and the family did not follow through for needed evaluations or services. Review teams identified that more training is necessary for DSS social workers and supervisors about mental health issues and how to access services.

When both agencies are involved with a family, the review teams found that better coordination was often needed in identifying a lead case manager. DSS and Mental Health in several of the communities need to better educate their staffs about the processes of each agency. The assessments of risk for children and families frequently differ between DSS and Mental Health, particularly when there is substance abuse by parents or developmental disabilities at issue. Cross training of DSS and DMH/DD/SAS staff in risk assessment is needed.

V. Conclusion

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 02-03 have made this report possible. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. The review team members intensively reviewed the circumstances of each child's death and confirmed that protecting children is a shared community responsibility.

The findings and recommendations of these multidisciplinary teams have statewide implications. It is recommended that state agencies and all local communities in North Carolina use this report to examine the issues relevant to the protection of children and the prevention systems in place in order to make any improvements that are indicated. If the lessons learned as a result of a child's death can be applied in such a way as to prevent future fatalities, the state's protection of children will be significantly enhanced and the legislative intent will be met.

Appendix A

Appendix A reflects additional recommendations that were either identified less frequently than those in the body of the report or that were case specific. These are important recommendations that can be implemented statewide.

Issues for Judges, Attorneys, and Law Enforcement

- Judges and attorneys making custody decisions in Domestic Violence situations should contact county Department of Social Services prior to making custody decisions to ensure that there are not conflicting with safety for the children.
- Judges and attorneys involved in a Chapter 50B protective order should state clearly that a court ordered protection cannot be violated when it is consensual or when children are involved.
- Services and visitation should be specifically ordered by judges and spelled out under the "decretal" section of the court order and section of conclusions of law, not just referenced in finding of facts and exhibits.
- Many District Attorney's Offices have no investigators that could coordinate a comprehensive effort to ensure all information around a child's death is completely explored. There should be advocation by State Representatives for more District Attorney Investigators to the General Assembly.
- When unsupervised visits are allowed by legal custodians between children and parents even though the legal custodians are told by the court and Departments of social services that is in violation of the court order there is no penalty. A criminal negligence statute at the felony level should be explored by the North Carolina General Assembly.
- When children are transported in a vehicle by parents who have been determined by law enforcement as legally impaired, law enforcement should report to DSS all persons who drive while impaired when children are at the time in the vehicle.
- Judges and District Attorneys should not be dropping or dismissing charges against a parent when they have not completed all that was ordered in court.
- Local law enforcement and local area mental health agencies should develop a protocol for law enforcement to have access to a mental health professional to assist with interviewing when the subject of the interview may have developmental delays.

Medical Examiner Issues

- North Carolina needs a Medical Examiner system that disseminates, distributes and applies the science and other information that exits in the central State Medical Examiner's office through every community and county requiring that information.
- There should be clarification regarding the difference between the role of a coroner and a medical examiner.
- Pathologist always should clearly specify the cause of death or that it cannot be determined in the final autopsy report.
- A protocol be developed by the State Medical Examiner's office and regional child abuse experts to rule out possible child abuse prior to ruling SIDS.
- Local Medical Examiners should meet personally with the law enforcement officer investigating a child fatality.

- Local Medical Examiners also should have contact with DSS to establish if there is history or knowledge relevant to the situation.
- Local Medical Examiner's should obtain pertinent information regarding the crime scene if they are not at the crime scene and should pass on this information to the pathologist.
- Pathologists and law enforcement should have direct contact and law enforcement should attend autopsies whenever possible.

Parenting Education

- Community Awareness around age appropriate supervision for children and potential risk posed when minor children are left to supervise.

Child Care Services

- Training on "identifying families in crisis" provided by North Carolina Division of Child Development can be helpful to daycare home providers.
- Daycare subsidy is not available for parents who exceed the income level for child day care assistance, but do not earn income to afford child care. The state and local Smart Start Program and the state and local More at Four Program should explore funding initiatives to provide parents with child care assistance who cannot afford childcare assistance.

Resistant Families in Child Protective Services

- Parent- initiated placements should be used when it is a short tem solution, the parent will participate and follow through with the case plan and it is not a substitute for bringing a child into custody because of safety issues especially when parents would not participate in the development or follow through with the case plan.
- The North Carolina Division of Social Services should review the utilization of safety plans as related to the legal authority to enforce them and provide guidance for county DSS agencies when the plan is not followed. Safety plans should be specific and monitored for compliance. When violation of the safety plan increases risk to the children, supervisors and workers should consult with attorneys regarding petitioning for custody.
- When a case has been opened for a Child Protective Investigative Assessment and a Safety Resource (alternative living arrangement) is still necessary because inappropriate behavior has not changed and safety issues remain if the child were to be return to the parent, the agency should not substantiate and then close the Child Protective Investigative Assessment until that Safety Resource (alternative living arrangement) is legally secure. The local DSS should petition the court for substantiated Child Protective Services cases and request a court ordered placement when safety issues warrant a Safety Resource (alternative living arrangement).
- When agencies make a referral for a family, they should follow up with the service provider to see if the family made an appointment or kept an appointment that was made when a child's wellbeing is at stake. The agency should be clear about what the response will be when an agreed upon plan of action is not carried out by the family.
- DSS supervisors should monitor work in any case on a weekly basis and assure the family being worked with carries out case plans. The local DSS management should set an expectation that a weekly case staffing will occur between workers and their supervisors.

- Children cannot be protected when legal barriers prevent service providers from gaining immediate access to children. Statutes must allow for immediate and objective access to children in an appropriate environment for assessment. It is imperative for children's safety to distinguish a person's property, which might be protected by constitutional right, from the lives of children who may need protection within the legal system. It should be remembered when considering laws pertaining to protection of children that parental rights can be in conflict with children's safety.
- The Division of Social Services should provide guidance to agencies in the form of specific policy, protocols and training for social workers when encountering resistant families, as this resistance in and of itself greatly elevates the risk to children.

<u>School Issues</u>

- Public schools should be more proactive when it comes to attendance. In addition to attendance being important for school achievement, it is also an indicator relating to the child's health and wellbeing. The local CCPT's should hold discussions with their school systems regarding more aggressive enforcement of existing policies including any legal recourse and to better educate the community about the truancy hotline and school options for ensuring school attendance.
- The State Child Fatality Task Force should look at the correlation of home schooling and protection issues for children.
- While County School Systems are careful about documenting incidents in children's records, some incidents are not recorded. The Department of Public Instruction should explore providing guidance to County School Systems on documenting a critical incident that has occurred with a child that attends one of their schools. This can allow the county school to follow the well being of the child throughout the remainder of the child's primary education. This is important because, while the incident may not affect the child right away, it can affect the child in years to come. If there is no documentation that the incident occurred, no one can help the child, unless the child verbalizes that he/she is suffering from the incident that occurred some time ago.

<u>Division of Social Services and County Department of Social Services Supervisory Oversight</u>

- DSS should encourage all agencies to call and discuss with them any case of suspected neglect. DSS also will suggest to agency callers that the CCPT is a resource if the concerns exist and it does not meet the criteria for neglect or abuse.
- On going training should be provided to social workers regarding chronic illness and medically fragile children as it relates to neglect and abuse by the Division of Social Services.
- The Division should look at policy clarification around identifying victim children in a family where they may not currently reside in the same residence as the alleged maltreating parent. Factors to be considered in identifying alleged victim children should include:
    1. Legal stability and permanence, as well as the authority of the caretaker to access services and make decisions.
    2. The maltreating parent's ongoing involvement with this child.
    3. Alternate caretaker's denial about the maltreatment issues relating to the maltreating parent.

4. When involved with families where potential victim children are not currently in the same home as the maltreatment parent. The DSS should minimum, have the requirement that caretakers and children are interviewed as collaterals.

- Consistent and thorough supervision should ensure all potential victim children are identified and assessed by DSS management.
- DSS should utilize after-hours workers to monitor supervision of families. DSS management should remind workers and supervisors of the importance of utilizing after hour's workers.
- The local CCPT's should become more of an active resource for the interagency staffing of particularly problematic cases involved with the County Department of Social Services.
- The local CCPT's should review regularly children's cases that are in the custody of the County Department of Social Services as a result of adjudication of delinquency or undisciplined behavior.
- Supervisors of DSS blended teams should ensure that all cases are staffed a minimum of once a month. DSS supervision should include continually evaluating whether new information should be taken as a new report for investigation. DSS should review its agency's mission, goals and the role of supervisors in meeting these goals.
- The local DSS should ensure that a multi-level ongoing accountability and quality improvement plan is in place to assure that CPS protocols are carried out.
- DSS supervisors should look at the quality of collateral contacts to ensure that they get the best information possible in order to ensure the protection of children.
- DSS should adhere to the state standard requiring a case decision within 30 days or provide documentation as to why the decision cannot be made within that time frame. DSS supervisors should ensure compliance with the policy.
- Team meetings should occur anytime that several agencies are involved in the same family. When DSS is involved they should initiate meetings with various agency personnel and establish roles and responsibilities for all the workers involved with the family. This community team should see that the intervention is tailored to the client to include cultural issues. DSS supervisors should ensure team meetings are scheduled as appropriate. Supervisors should consider attending team meetings with inexperienced workers.
- Close attention should be paid to determining who might be able to provide objective information in which to verify parental reports.

<u>Medical Issues</u>

- All group homes should adhere to Mental Health Licensure rules set forth by the Division of Facility Services. Drug administration errors and significant adverse reactions should be reported immediately to a physician or pharmacist. An entry of the medication administered and the drug reaction should be properly recorded in the drug record.
- The Division of Social Services should review and revise the current health component form DSS#5125 to allow space for extensive medical history.
- The county DSS should establish a policy to forward any medical information of the child that was received while the child was in custody to the parent upon return of child to parent.
- The local CCPT should advocate to prescribing physicians, service provider agencies, and medical case management teams in the community about the importance of following medical protocol in conducting medical assessments, including a review of all medications and diagnoses of a patient and the possible side effects on a scheduled basis.

- The Department of Medical Assistance should review eligibility criteria of programs for medically fragile children to consider the needs of the child and the family regardless of birth order.
- All health workers should be educated about how to identify the risk factors and the importance of a complete medical history in the identification of risk during prenatal care. Health Departments and community health clinics should ensure that prenatal care includes information to be obtained and given regarding health risks to unborn children, particularly when health issues and substance abuse may significantly affect birth outcomes.
- All Area Mental Health contracts with umbrella agencies who then contract with an individual to provide services to developmentally disabled and medically fragile children should be required to perform finger printing of respite providers and to do criminal background checks.
- Division of Facility Services should be required and have the ability to access central registry of all potential providers to chronically ill, medically fragile, and developmentally disabled children to be checked for past statewide child protective history.
- The Division of Medical Assistance should implement and monitor policy and procedures for direct enrollment providers that will ensure the safety, health, and quality of care provided to children associated with DSS, Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS), and Division of Facility Services (DFS). DMA should serve as the lead agency in developing this protocol with consideration of impact to DSS, DMH/DD/SAS, and DFS. Provider agencies should then develop tools for implementation of this policy which should include responsibilities for both family and provider agencies. This is necessary in order to ensure the provider has the necessary knowledge, competencies, skills, and equipment to care for children and should be a requirement for the agency to provide services. This plan should include the case manager being able to both provide quality assurance and have the authority to address whatever problem is identified when a service has been approved.
- State hospitals do not have a policy or resources to track outcomes of children after the children have been discharged. The State General Assembly, Department of Health and Human Services, and Division of Mental Health should investigate funding resources.

<u>Crisis Debriefing</u>

- Crisis debriefing to first responders should continue to be offered.
- Crisis debriefing should be extended to DSS staff.
- A protocol should be established for first responders to offer information regarding services for survivors of catastrophic events.
    - It is recognized that family members suffer from grief when there has been a child fatality. The county DSS should assist with arranging grief and family counseling for all appropriate family members following a fatality.

Appendix B

Appendix B reflects some of the achievements reported by local communities that resulted from recommendations from State Child Fatality Reviews.

- The Family Center in Alamance County hosted several workshops on the effects of shaken baby syndrome when baby sitting babies to middle school and high school students.
- Cleveland County CCPT/CFPT is doing health/safety segments about children on Channel 33.
- Cleveland County and Gaston County together hosted SIDS Training for their community.
- Caldwell County Department of Social Services and Caldwell County Community Child Protection/Child Fatality Prevention Team are having two social work teams provide education on the Infant Abandonment Prevention Law.
- A partnership between Cooperative Christian Ministry, Catawba County Department of Social Services and The Faith Community Task Force on Poverty have executed a program that provides transportation for low-income families who are working toward economic self-sufficiency by obtaining, maintaining, or improving their employment by awarding them a vehicle.
- Catawba County Department of Social Services is sponsoring a Nurturing Father's Program. This program is created specifically for fathers who desire to cultivate attitudes, values, and skills that would best support growth, development, and stability within the family.
- SCAN of Forsyth County were one of the first agencies to execute a protocol in response to the Infant Abandonment Law, which has been presented state-wide.
- Gaston County Child Advocacy Center, Child and Family Service Teams, Pathways and Department of Social Services have implemented mandated protocols to ensure coordination of case management for children.
- Union County Partnership for Children, Smart Start, and United Family Services together provide classes for the Spanish speaking community in Spanish on fatherhood, parenting, discipline, sexual abuse and shaken baby syndrome.
- Prevent Child Abuse Team of Wilkes County and the United Way sponsors the Kids 'N' CARS campaign, a public awareness campaign to educate the community not to leave children in cars alone.